THE MIDWIFE IN CHICAGO

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The problem of the training and control of midwives has been for sometime recognized as a serious aspect of the effort to prevent infant mortality and needless invalidism on the part of child-bearing women. It is estimated that 40 per cent of all births in the United States are attended by midwives. In New York the estimate is 39.2 per cent, in St. Louis 75 per cent, in Wisconsin as a whole 50 per cent. While the figures for Chicago have not been officially published, from examination of the books of the county clerk it appears that there were registered by midwives during 1913 19,713 births as compared with 19,729 registered by physicians, or approximately 50 per cent.

Discussion of what shall be done to protect the mothers and babies from the untrained and therefore careless, dirty, and dangerous midwife has been general during recent years and has divided the laymen and doctors into two opposing camps. Before entering upon the discussion of the remedies proposed by the two groups, attention should be called in the first place to the importance of recognizing as a serious element in the situation the attitude of mind among foreign women regarding their treatment at time of childbirth. In fact the "midwife problem" is an excellent illustration of the necessity of considering the traditions and prejudices of our immigrant population before approving any proposed solution. The problem has in fact largely to do with the foreign-born groups. Midwives in Chicago are almost all of them foreign born, live in foreign neighborhoods of the city, and have a practice confined almost exclusively to immigrant women.[1]

[1] An analysis of 1,076 births registered in 1908 showed that among Italians 86 per cent were reported by the midwives; among the Austrians, Hungarians, Poles, and Bohemians, 74 per cent; among the Germans, 68 per cent; among Russians, 25 per cent ("The Midwives of Chicago," *Journal of the American Medical Association*, Vol. L, No. 17, p. 1346).

While midwives are commonly used by the poorer people of England and were relied upon by American women in the Colonial period and in the early part of the nineteenth century, they are little used at the present time by women of native parentage. Those who are interested in securing the best obstetrical care for American women of native stock only can devote their attention to the elimination of the ignorant and poorly trained doctor. But more than this must be done if the immigrant woman is to be protected against the ignorant and untrained midwife, for it is not because she believes that the doctors are poorly trained that she insists on the midwife.

The immigrant preference for the midwife is due in part to the very different position which she occupies in Europe. There, good schools of midwifery are numerous, and in most countries the midwives who are licensed are carefully supervised by the state. In the United States quite the reverse is true. A difference of this sort is always a difficult thing to make clear. The women are quite as likely to conclude that because we do not use midwives, American women do not know how competent they are, as to follow our argument that because they are less competent Americans prefer a doctor. But this difficulty is not so insurmountable as the prejudice against the assistance of a man during childbirth, so deep that it is only when a physician is urged as a matter of life and death that his attendance will be tolerated by the patient or excused by her circle of friends. That this prejudice will undoubtedly disappear with longer residence in this country may be true, but other women are constantly arriving with the same prejudice, so that its consequence must be faced as, in a sense, a permanent obstacle to the use of the physician. For this reason a Joint Committee of the Chicago Medical Society and Hull House which conducted an investigation of "The Midwives of Chicago" in 1908 declared that the members of the committee "were fully convinced that midwives now and probably for years to come are socially inevitable,"[1] and that the investigation "showed many inadequately trained, ignorant women practicing as midwives and in many cases ready to assume charge of abnormal cases and

[1] *Journal of the American Medical Association*, Vol. L, No. 17, p. 1345.

to perform abortions." The committee therefore recommended as the first steps in the improvement of this situation that the law governing the licensing of midwives be made more stringent, and that all schools of midwifery should be placed under the supervision of the state Board of Health. These recommendations were never carried out, and the question has therefore arisen again as a consequence of this inaction.

It might be argued that inasmuch as nothing had been done, conditions had probably not improved and that further investigation would only reveal what was already well known. There is, however, a group of people who believe that anything which gives the midwife greater skill means a larger following, while if she is ignored she will eventually disappear. Although nothing has been done, they urge, then, that the situation may still have improved. It has therefore seemed best before formulating any plan for meeting the present Chicago condition to bring down to date the material secured in 1908. The Immigrants' Protective League therefore undertook such an investigation after consultation with a number of those interested in the preparation of the report in 1908. The schedule used was prepared with the assistance of a doctor who has had many years' experience in lying-in dispensary work among the foreign-born.

The names and addresses of the midwives and the number of births each had reported during three months of 1913 were copied from the records of the county clerk. These formed a working list for the investigation. One hundred and eighty-two schedules were then secured from a representative number of these midwives and from others who were found in the various foreign neighborhoods in the course of the investigation. The schedule included information as to the general education and training of the midwife, the condition of her bag, her house, and person, and also as to the number, nature, and care of the cases diagnosed as abnormal in 1913, the number of examinations made during labor, the treatment of the third stage of labor, the number of lacerations and by whom repaired, what is done to prevent *ophthalmia neonatorum*, and a number of other questions which gave the investigator an opportunity to judge what in general are the midwife's standards of care

and treatment and whether she is overstepping the bounds of her profession.

Because of the way in which records of those licensed have been kept by the County Clerk, the number of midwives practicing in Chicago can only be estimated. These records do not contain separate lists of midwives, but instead, together with the doctors and the osteopaths, they are entered in the chronological order in which they are licensed, so that the whole list would have to be carefully checked in order to find the number of midwives that have been licensed. How many of these have died, moved away, or given up practice there is no way of determining. There are 432 listed in the last city directory; 475 registered births during the three months that were covered in the examination of the books of the county clerk. That there are many, both licensed and unlicensed, who do not register births is unquestionable. A number of those from whom schedules were obtained said they never registered births because it was not worth the trouble. While the licensed midwives are probably not any more remiss than doctors in this particular, those who are unlicensed either do not register the births or register them through some doctor with whom they have a friendly understanding. It has been noted that 19,713 out of 39,442 births registered were registered by midwives. This probably means that more than half the births in the city are attended by midwives, which is an increase over the year 1908, when only 47 per cent of the registered births were reported by midwives.[1]

The seriousness of the problem is measured of course by the extent of the practice taken in connection with the lack of training. It is not uncommon for a midwife to have a very extensive practice, though there is naturally much difference in this respect. Table I based on figures taken from their records by those midwives from whom schedules were obtained, shows the large number of cases handled by some of them. Three of the Italian women said that during 1913 they attended 600 births. During the three months covered by the examination of the county clerk's records 71 midwives registered fewer than 50 births, 345 registered from 50 to 100, and 41 registered from 101 to 150.

[1] *Journal of the American Medical Association*, Vol. L, No. 17, p. 1346.

But the more serious aspect of the midwife situation is their lack of training and freedom from supervision. For, as Miss Van Blarcom, secretary of the New York Committee for the Prevention of Blindness, points out, in Denmark "although midwives attend between 90 and 95 per cent of all births in the country, there is neither the same high death-rate among infants nor the relative amount of unnecessary invalidism which exists in this country."[1]

TABLE I

SHOWING NUMBER OF BIRTHS ATTENDED BY MIDWIVES OF DIFFERENT NATIONALITIES FROM WHOM SCHEDULES WERE SECURED

NATIONALITY OF MIDWIFE	NUMBER OF BIRTHS ATTENDED BY EACH MIDWIFE						
	50 or Fewer	51 to 100	101 to 150	151 to 200	Over 200	None or no Report	Total
Polish	45	25	7	5	1	11	94
Italian	8	4	3	4	7	1	27
Bohemian	11	6	3	1	1	1	23
German	2	4	1	.....	.....	4	11
Slovak	4	1	1	.....	.....	2	8
All others	11	3	3	.....	.....	2	19
Total	81	43	18	10	9	21	182

Examining and licensing are regarded as the first steps in a proper control of midwifery. In Illinois, midwives are licensed by the state Board of Health under the provisions of the Medical Practice act of 1899.[2] They are required to take a written examination in physiology, hygiene and antisepsis, anatomy, and care of mother and child. Candidates for licenses are not required to have either a general education or any training for midwifery. For a medical practitioner the state fixes the standard of general education and medical training that are prerequisites for a medical degree and requires an examination in addition, while in the case of a midwife, merely passing an examination in theory is all that is required. It is not surprising, therefore, to find that the only training thought necessary by women who expect to be midwives is to secure someone familiar with the type of questions usually asked to coach them

[1] Carolyn C. Van Blarcom, *The Midwife in England*, p. 13.

[2] Illinois Revised Statutes, chap. 91, sec. 6.

for the examination. During the few weeks or months when answers are being hastily memorized, their only concern is whether they will be able to remember this undigested mass of information when they take the examination.

How many of those who are practicing have undergone even this test cannot be ascertained. Seven from whom schedules were obtained said they were practicing without being licensed, ten others were unable to produce their licenses. They gave all kinds of excuses, and each promised to send the next day the number of her license but none did so, and the investigator was convinced that none of them had passed the examination required by law. The records of the county clerk were searched for several of these, and they were not found on the books. One woman reported that she practiced with the "permission" of the doctor with whom she was studying on condition that she took two other women from the "school" with her. Two others were "authorized" by a doctor to put out their signs on condition that they called the doctor to assist them. As there is no provision for the supervision or investigation of midwives by the state Board of Health, it is to be expected that even the present law, inadequate as it is, will not be enforced.

A knowledge of English is not necessary for those desiring to take the examination. Translators may be provided by the applicants, and in practice these are usually the doctors who have trained them. The translators are seated at one end of the examination room and the monitors employed by the state Board of Health take the translations of the questions to the applicant. The official translator employed by the state translates the answers into English and the papers are then graded.

There are in Chicago no schools of midwifery worthy the name. One doctor who "trained" fourteen of the midwives from whom schedules were received gives one or two hours' instruction five days a week, for six months. The only requirement for admission to this school is ability to read and write and the possession of the money for tuition—$100. The school is held in the physician's office, which was found to be dirty and confused. At the first interview with him the doctor was found to have been drinking, so that he was not able to talk coherently. Another physician

with whom twenty-seven of those from whom schedules were obtained had prepared for the examination calls himself and his office a "College of Midwifery." Instruction, he says, is by lecture, textbook, manikin, and skeleton. Students are not required to witness any definite number of deliveries, but are taken with him as often as possible. One Polish midwife, who reported that she attended 138 births in 1913, had never been to school at all before she began to study midwifery. She had learned to read a little at home, and during her nine months' preparation for the examination in midwifery she learned to write. She did not, during training, attend a single birth. How much of the theoretical work which she was given in lectures could be understood by a mind so untrained can be imagined. After five years of practice she was unfamiliar with the names of the solutions she used, and relied in case of an emergency upon the drugstore for advice. She diagnosed as abnormal 35 cases in 1913. She says she often treats such cases and makes it a habit to repair lacerations unless they are quite serious. Another midwife who finished the fourth grade at school attended 35 "lectures" in preparation for her examination. She had witnessed no births during training, and explained quite simply that when she was called to her first case she was very much frightened, but "God helped her and the birth was very easy." An illiterate Italian midwife, who was herself untidy in appearance and whose bag was very dirty, explained that she "uses old methods but always has good luck." A Polish midwife who finished the third grade in school paid $150 for a nine months' lecture course with a local physician. She has herself had 12 children of whom 5 died, and thinks her own experience has been of the greatest professional value. Her husband is sick with tuberculosis, so that she feels the need of greatly extending her practice.

Because the examination is entirely theoretical, graduates of reputable schools of midwifery with years of experience often find themselves less able to pass than the ignorant woman who has never witnessed a delivery but has been carefully coached for the questions usually asked. One such trained woman has taken six examinations and has spent over $300 for fees and for interpreters, and has not yet secured a license. She has applied again and again

to social agencies asking if there is not some good school which she can attend in order to learn "American" methods, which she feels sure are not properly taught by the doctors who are conducting schools of midwifery in her neighborhood. To her these doctors seem poorly trained themselves and careless in their habits, as well as often vulgar in speech.

Out of the 182 midwives from whom schedules were secured, 57, like this woman, were graduates of European schools of midwifery. These may be assumed to be well trained. The remaining 125 have had only the most ridiculously inadequate training. Most of them have had very little general education. Fifty said they had never gone beyond the fourth grade, and 91 others had not gone beyond the eighth. One was illiterate, several could read and write only with the greatest difficulty. Their professional training is equally unsatisfactory.

Some of the midwives who are intelligent and well trained are unfortunately not in the habit of taking the precautions which they know to be necessary for surgical cleanliness. This is probably in part due to the fact that they are no longer subject to the supervision to which they had been accustomed at home and in even greater part to the fact that the standard of midwifery is so low in this country. A midwife would not feel free to call a good doctor in case of a complication, and so those who are well trained are demoralized by the doctors as well as by the American-trained midwifes with whom they come in contact.

To many of the midwives surgical cleanliness is entirely unknown. This was indicated, among other things, by the condition of their bags. Twenty-one of the bags inspected were found to be dirty; while fifty-four could be called only fairly clean. Under such circumstances, the care of normal cases is dangerous, and the willingness to undertake abnormal ones is alarming. Seventy-one said quite frankly that they themselves treated cases which they diagnosed as abnormal, but that when these proved to be very serious they called in a doctor. Many of the women had pills and instruments in their bags, although the use of either constitutes a violation of the Medical Practice act for which they may be fined. One who had instruments explained that she charged $15 extra

whenever an operation of any sort was necessary. Some complained of prosecution for such practice, maintaining that they had been falsely accused.

In the course of the investigation, evidence of criminal practice was forced on the attention of the investigators, and many midwives reported their competitors as willing to perform abortions. No attempt was made to verify these stories or to secure any evidence as to the extent of this criminal practice among them for the reason that it is believed to have little or no relation to the education or training of the midwife. While perhaps more dangerous to the woman, it is no more criminal for the ignorant midwife to perform illegal operations than for the well-trained doctor. At any rate, while difficult of enforcement, the law fully covers this practice and special attention to this aspect of the problem seemed unnecessary.

The general standard of care given by the midwife is indicated by the precautions taken to prevent blindness through *ophthalmia neonatorium*. The use of a solution of nitrate of silver is now regarded as a simple protection against this disease which should never be omitted. Of the midwives interviewed, only 10 said that they used it in every case, 18 others said if the baby's eyes were "inflamed," "red," or "sore" they used nitrate of silver, 98 said they always used boracic acid, while 4 others said they used boracic acid only in cases of inflamed eyes; 15 used other solutions, and 25 used water. One said she used water only when there was evidence of inflammation. One woman reported that her treatment for either "red spots on the face" or "red eyes" was to rub them with the mother's placenta for two or three days. Another said she used the mother's milk, which is in fact commonly regarded as a cure. Several of them knew they should use nitrate of silver, but said they were "afraid to"—meaning that they feared prosecution for the illegal use of drugs.

That other recognized precautions are omitted is indicated by the fact that 32 of those interviewed said that during 1913 they had cases of infected cord. These and many other illustrations which could be quoted from the schedules show quite conclusively that a very large percentage of the midwives are quite unprepared to care even for normal cases.

With more than 50 per cent of the births of Chicago attended by these women who are for the most part quite untrained, infant mortality, preventable blindness, and cases of serious invalidism or of deaths of mothers are greatly increased. As has been said, there is difference of opinion as to the steps necessary to lessen these evils. It is admitted by everyone that the midwife with all her faults is not responsible for as many deaths as the ignorant doctor who refuses to recognize his limitations.[1] It is also generally agreed that the midwife, however well trained and supervised, can never furnish the best standard of obstetrical care, which can be given only by the doctor who has been well trained in obstetrics. All agree that certainly one conclusion from these two postulates is that much greater emphasis must be laid on the place given to obstetrics in medical colleges. But there is much difference of opinion as to whether the training and supervising of midwives should be regarded as any part of a program for providing better care for all mothers.

The argument against the midwife is, briefly, that she is of course not a doctor and that a well-trained doctor to attend every woman during childbirth is the ideal toward which we should direct our efforts. Any attempt to train midwives, say those holding this view, means that clinical opportunities which are needed for medical students will be given to these women.

Those who oppose the training and supervision of midwives do so, not because they are ignorant of the very large numbers who rely upon them now, but because they are persuaded that the midwife's patients are too poor to pay a doctor and so their remedy is the elimination of the midwife through the establishment and extension of medical charities—hospitals and dispensaries.[2]

It is at this point that the fundamental error is made. In most cases the immigrant woman, as has been already pointed out, employs a midwife, not only because she is cheaper than a doctor, but because the woman prefers a midwife to a doctor who is a man.

[1] Dr. J. Whitridge Williams, *Proceedings of the American Association for Study and Prevention of Infant Mortality* (second annual meeting), p. 192.

[2] Dr. Charles Edward Ziegler, "The Elimination of the Midwife," *Proceedings of the American Association for Study and Prevention of Infant Mortality* (third annual meeting), pp. 31–32.

Social workers who have tried to persuade a woman of this type to accept dispensary care can give much testimony on this subject. The case of the Polish woman who was dependent upon charity because of the illness of her husband and who refused to have a doctor attend her, even when she was threatened with the withdrawal of all relief, is not unique. In her case the neighbors, although themselves poor, contributed toward the payment of a midwife in order that the woman should not be made to suffer the "shame" which the society had suggested to her.

It is unnecessary to point out that little by little, especially when there are some women physicians on the staff, the dispensaries gain the confidence of the women in spite of this social taboo. Among the Russian Jews, in whose neighborhood dispensary service was first organized, much progress has been made. But although the work of such dispensaries has been much extended in recent years and an increasingly effective and sympathetic force of visiting and infant-welfare nurses who co-operate with the dispensaries in the effort to supplant the midwife is now available, the percentage of births attended by midwives has increased. All of this is, of course, an argument for more dispensary service, but to those who are considering the welfare of the women of today and of twenty or fifty years hence it seems also an argument for making some effort to raise the present standard of midwifery.

The physicians and laymen who believe that the midwives should be trained, licensed, and supervised do not believe obstetrics to be an unimportant branch of medicine. They do not hope to make a doctor out of a midwife. They do believe that it is immediately necessary to train the midwife so that she will be clean and careful in the care of normal cases, that she will summon a doctor in case there is evidence of any abnormality, and will be able to bathe and care for the mother and baby, and, what is equally important, will teach the mother the care of herself and her baby better perhaps than a doctor is able to do.

Illinois has, as has been said, taken the first step in the direction of regulating the midwife. The law recognizes midwives and authorizes them to practice if they have passed the examination given by the state Board of Health. How inadequate this step

is has already been shown. Very little more has been done in any other place in the United States. In twelve states,[1] Connecticut, Illinois, Indiana, Louisiana, Maryland, Minnesota, Missouri, New Jersey, Ohio, Utah, Wisconsin, Wyoming, and in the District of Columbia, midwives are required to pass an examination before receiving a license. In Illinois, Maryland, Missouri, New Jersey, Ohio, and Wisconsin, midwives are restricted by law to attendance on normal cases.[2] In Colorado, Iowa, Kansas, Montana, Nevada, North Carolina, and Washington, the statutory provisions are irregular and so meager as to be practically without effect.[3] In New Jersey, Ohio, and Wisconsin, the law requires that midwives shall be trained before being licensed, but as there are no accredited schools in those states, there is no possibility of enforcing the law.[4]

Since 1907, the Department of Health of the city of New York has had the power to adopt rules and regulations governing the practice of midwifery in that city.[5] Under this authority rules have been adopted requiring (1) that permits to practice midwifery must be renewed each year; (2) that the applicant for such a permit must be twenty-one years of age, must be able to read and write, must constantly show evidence of habits of cleanliness, and must present a diploma or certificate showing that she is a graduate of a school for midwives which is approved by the state Department of Health.[6] The last requirement was, however, waived in the case of all those who had been previously authorized to practice midwifery by the board.[7] The only approved school is the one conducted in connection with Bellevue Hospital, which is the only good school of midwifery in the United States.

The Department of Health has also adopted rules governing the practice of the midwife in New York City. These include an

[1] Carolyn C. Van Blarcom, *The Midwife in England*, p. 16.

[2] *Ibid.*

[3] *Ibid.*

[4] *Ibid.*, p. 17.

[5] Laws of 1907, chap. 432.

[6] Rule 3 adopted by the Board of Health of the Department of Health of the city of New York, October 14, 1913, to take effect January 1, 1914.

[7] *Ibid.* Before the adoption of this rule, the applicant must have attended under the instruction of a licensed physician at least twenty cases of childbirth.

enumeration of the conditions under which a physician must be summoned, the equipment the midwife must carry with her, and what solutions she should use. The enforcement of these rules is under Dr. S. Josephine Baker, director of child hygiene. The inspections are made by five medical inspectors and nine nurses, and on the basis of their reports as to whether the rules of the department are being followed, the permits of the midwives are renewed or revoked. New York City has thus the beginning of a system which will, if developed, do much to improve the standard of midwifery.

New York state has in the past lagged far behind the city, although the problem was relatively more important in the smaller localities because of the absence of medical charities. In November, 1914, however, the state Board of Health, in accordance with the authority to amend the sanitary code given it in 1912, adopted regulations which will raise the standard very much. These regulations are practically the same as those in New York City except that applicants, although not graduates of a recognized school for midwives, may secure a license if they are able to present evidence of having "attended, under the instruction of a duly licensed and registered physician, not less than fifteen cases of labor and have had the care of at least fifteen mothers and newborn infants."[1] With this system of annual licensing, if intelligent and sympathetic supervision is provided, much will be accomplished in New York.

As representing the other point of view, Massachusetts deserves some special consideration. Quite by intention and not by neglect as in many states, the midwife in Massachusetts is omitted from the Medical Practice act and so cannot legally practice. However, by one of those curious contradictions which legislatures sometimes enact, she is required to register the births she attends. The fact that she complies with the law in this particular has been occasionally used to convict her of illegal practice, but the midwife is generally tacitly allowed to practice in Massachusetts, and she is encouraged to register births in many cities.

[1] *Sanitary Code*, New York, chap. iv.

Those who have been most interested in improving obstetrical practice in Massachusetts, believing that all efforts in this direction were worse than futile, have steadily opposed all plans to license, train, or supervise midwives. An investigation, made in 1909 in regard to the prevalence of *ophthalmia neonatorum* as a part of the work of a "Committee on Birth Returns and Midwives of Boston 1915," showed 104 midwives to be practicing in Boston and the most important mill towns of the state. This number was felt to be so small in view of the very large number of recent immigrants in the state that it is always cited in support of the theory that the Massachusetts policy of prohibiting the midwife by law and ignoring her in the administration of the law has made the problem much less serious than in New York and other states where something more has been attempted. The *Report of the Massachusetts Commission on Immigration* (1914) showed, however, that the earlier report greatly underestimated the number practicing in the cities and towns covered in the investigation, and says that "although contrary to law, an increasingly large number of immigrant women are attended during childbirth by midwives, many of whom are untrained and irresponsible," and urges "the medical profession and the state to face this problem at once and decide on some method of protecting immigrant women from these absolutely untrained and irresponsible practitioners."[1]

European practice would have proved a valuable source of information as to what might be done in the way of standardizing midwifery, but the opponents of supervision have insisted that rules and regulations which could be enforced in Germany, Austria, Italy, or Denmark could never be successfully administered in the United States. This reasoning will not, however, allow us to disregard the successful beginning which has been made in England where conditions were in many ways analogous to those in this country. In England as in the United States many midwives who were ignorant and untrained were already practicing. Their practice was very much more general among the poor than in this country. After extended discussion of the whole subject and in the face of considerable opposition, an act was passed in 1902 to

[1] Massachusetts House Records, No. 2300, 1914, p. 196.

become completely operative only in 1910. After that time any woman desiring to be registered or licensed as a midwife was required by law to be a graduate of a training school, to pass a written and oral examination given by the Central Midwives Board, and to conform to the rules and regulations regarding the practice of midwifery established by the Central Midwives Board. Under these provisions, three classes of midwives are now practicing: (1) the "bona fide" midwives who were certified because they had been in practice one year prior to the passage of the act; (2) those certified because they held certificates from an approved school; and (3) those who have passed the Central Midwives Board examination.

The local administration of the law is in the hands of the Council of the Counties and County Boroughs who are known as local supervising authorities. The executive officer is the local medical officer of the board of health. For a violation of regulations made by the Central Midwives Board, the midwife is first warned, then placed on probation or suspended from practice by this board. The actual supervision of the midwives is done by the inspectors employed by the local supervising authorities. While the success of the supervision must of necessity vary under this system of local administration of the law, Miss Van Blarcom, who studied the system in the rural districts as well as the manufacturing towns, found the spirit of the work and the results sought most commendable. The inspectors have apparently introduced a new kind of inspection. The midwife is visited at home, she is accompanied on calls, and her patients are occasionally visited by the inspector, but no attempt is made to frighten or intimidate her. The object of this inspection is not so much to discover the woman who is untrained as to teach the old, "bona fide" midwife, who is usually untrained, and to counsel and advise those who have attended good schools but are still inexperienced practitioners. The English regulation of midwifery seems therefore to be an attempt, not only to raise the standard for future licensing, but by patient visiting and advice to improve the methods of the old midwife who because of her following could not be successfully abolished by law.

This seems to be a system applicable to the situation in the United States. The greatest obstacle to regulation is the fact that in this country the midwife is used principally by the immigrant women, while in England the fact that her patients were English may have influenced public opinion.

Since the licensing of practitioners is a state function, to meet the need of the Chicago situation, an amendment to the statutes containing the following essential features should be obtained: (1) training in a school approved by the state Board of Health; (2) licensing after examination; (3) annual renewal of license without cost provided the midwife has observed the rules and regulations of the board; (4) supervision of the practice of midwives. In Chicago this supervision should be given by the Department of Health, in other parts of the state by the state Board of Health.

Until there is a reputable school of midwifery, however, the passage of a law containing such requirements would be of little use. It is therefore important that effort should be first directed toward the establishment of a school. In the investigation made by the Immigrants' Protective League the midwives were asked whether they would take such a course were it offered. Some replied that they were too old, some were too busy, and a few thought their training entirely adequate. Seventy-one said they would be glad to attend a school if it offered practical work. In Chicago, such a school would be logically connected with the Cook County Hospital in which there is a great maternity ward. As medical students are not admitted to this ward, this would not mean the sacrifice of medical students to the training of midwives.